STATE OF CONNECTICUT

INSURANCE DEPARTMENT

Testimony of the Connecticut Insurance Department
Before the

Insurance and Real Estate Committee

Thursday, February 11th, 2010

House Bill 5009—An Act Concerning Wellness Programs and Expansion of Health Insurance Coverage

The Connecticut Insurance Department would like to offer the following comments on House Bill 5009—An Act Concerning Wellness Programs and Expansion of Health Insurance Coverage.

In 2009, the Connecticut General Assembly enacted, and the Governor signed into law, Public Act 09-179, An Act Concerning Reviews of Health Insurance Benefits Mandated in this State. Public Act 09-179 establishes a Health Benefit Review Program within the Insurance Department and requires the Insurance Department to contract with the University of Connecticut's Center for Public Health and Health Policy to perform the evaluations and analyses according to statutorily defined criteria. These reviews include a list of any prospective mandated health benefits that the General Assembly's Insurance and Real Estate Committee plans to introduce each legislative session and requests to be evaluated. In addition, the law requires that there be a retrospective review of all statutorily mandated health benefits existing on or effective July 1, 2009.

The reviews must include both the social and financial impacts of mandating health benefits and the law outlines 25 different factors that must be analyzed, to the extent information is available, for each existing or proposed mandated health benefit.

In order to accomplish this comprehensive evaluation, the Insurance Fund, established in section 38a-52a of the general statutes, will be used to fund this program. Assessments will be made against insurance carriers, in addition to any taxes and fees that are paid, and the funds generated will be used to carry out the health benefit review program required under this public act.

On July 30th, 2009, the Co-Chairs of the Insurance and Real Estate Committee wrote the Insurance Commissioner to request a review of mandates pursuant to Public Act 09-179. Specifically, they requested that the Department review the proposed health benefits contained in Public Act 09-188, which the Governor vetoed:

- an increase in coverage for ostomy appliances and supplies;
- an expansion of coverage to include prosthetic limbs;
- an extension of coverage for hearing aids for children up to age 19;
- an extension of coverage for wigs to people who suffer from alopecia areata;
- an expansion of coverage for human leukocyte antigen testing;
- an expansion of coverage for colonoscopies; and,

- a requirement that insurance plans offer wellness incentives.

The Connecticut Insurance Department, in conjunction with the University of Connecticut's Center for Public Health and Health Policy completed their review of the mandates outlined above. The report was submitted to this committee on December 28th, 2009, and each member received a copy of the report. The Executive Summary of the report is attached to this testimony and a complete copy of the report is attached as well. Also, a copy of the report can be accessed on the Connecticut Insurance Department's website:
http://www.ct.gov/cid/lib/cid/Mandated_Benefits_Review_Project_2009.pdf

Finally, the Connecticut Insurance Department and the University of Connecticut's Center for Public Health and Health Policy have already initiated its review of all statutorily mandated health benefits existing on or effective July 1, 2009. We look forward to sharing the results of that analysis with the Insurance and Real Estate Committee on January 1, 2011.

The Connecticut Insurance Department appreciates the opportunity to comment on House Bill 5009.

Executive Summary

Pursuant to Public Act 09-179, the Chairs of the Insurance and Real Estate Committee of the Connecticut General Assembly (the Committee) directed the Connecticut Insurance Department to review the proposed health benefits contained in Public Act 09-188, An Act Concerning Wellness Programs and Expansion of Health Insurance Coverage, in accordance with the requirements stipulated under Public Act 09-179. This review has been performed in accordance with that request and has been a collaborative effort of the Connecticut Insurance Department and the University of Connecticut Center for Public Health and Health Policy, with the assistance of the University of Connecticut Center for Economic Analysis and Ingenix Consulting.

Public Act 09-188 included seven proposed new health insurance benefit mandates: 1) an increase in the minimum annual benefit for ostomy supplies; 2) an new mandate to cover the cost of prosthetics at least to the extent that Medicare covers them; 3) an increase in the age limit for coverage of hearing aids for children from under age 13 to under age 19; 4) coverage of wigs for persons with alopecia areata comparable to the current coverage for wigs for chemotherapy patients; 5) a new mandate to cover human leukocyte antigen testing for members enrolling in the National Marrow Donor Registry; 6) elimination of cost sharing for the second or subsequent colonoscopy performed in the same policy year; and 7) a new mandate that group health insurers offer a wellness program with financial incentives for employee participation as an optional benefit. Each proposed mandated benefit was studied separately and the key findings of these studies are reported below.

Existing health insurance coverage

Existing insurance coverage for these services differs by mandate. Some of the mandates are already included in policies offered by some of the health insurers in Connecticut. Others are not offered currently by any of them. In summary:

- Three insurers provide unlimited coverage of ostomy supplies and appliances under their group plans; another provides unlimited coverage for 28 percent of its insureds in group plans; one insurer provided $2500 annually and two insurers provided $1000 annually in coverage for ostomy appliances and supplies in group plans. Five of the seven insurers offered individual health insurance policies. Of these, one insurer provided unlimited coverage and the remaining four insurers provided $1000 annually in coverage for ostomy appliances and supplies.
- All seven insurers include coverage for prosthetic devices in group and ASO plans, some at the level of the proposed mandate. Coverage of prosthetic limbs is not included in all individual plans
- No CT insurers currently provide hearing aid coverage for children from 13-18, although 2 companies are scheduled to add it in October 2010.
- No CT insurers currently provide benefits for wigs for individuals with alopecia areata.
- Three insurers provide no coverage for initial HLA testing; the other four provide coverage of HLA testing based on medical necessity. It is unclear whether such coverage would comply with the proposed mandate.
- One of the seven CT insurers has eliminated the co-pays for a second or subsequent colonoscopy in a policy year.

- Most insurers offer wellness programs, and most offer at least some wellness programs with financial incentives. The extent to which employers elect to include wellness programs in their health plans and make them available to their employees is unknown.

Cost of proposed mandates

The estimated medical cost of the individual mandates is shown below. The vast majority of the incremental expense for the first six mandates is medical cost. 2010 medical cost is estimated to be $0.51 per member per month (PMPM) as a medium-cost scenario for all six mandates combined. Administrative costs are estimated to be $0.18 PMPM for these six mandates combined. For total retention, we estimate $0.21, which is administrative cost plus profit.

This yields a total cost of about $0.72 PMPM for the six mandates.

With the optional wellness program with incentives benefit mandate, however, the cost will not be a medical claim expense, but rather an administrative one. The estimated cost of this mandate will vary depending on the complexity of each program.

Summary of Expected Medical Costs of Mandates in 2010

1. Ostomy supplies:	$0.01 PMPM
2. Prosthetics:	$0.35 "
3. Hearing aids:	$0.06 "
4. Wigs, Alopecia areata:	$0.02 "
5. HLA testing	$0.06 "
6. Colonoscopy	$0.01 "
Total	$0.51 "

7. Wellness Programs	0% to 3% of premium

(This depends on the complexity of the wellness/incentive program.)

Financial burden on insureds

None of the proposed mandates were found to affect the existing health care financial burden for enrollees. Those who already have a high financial burden related to health care costs (i.e., more than 10% of gross income) would continue to bear a high financial burden. Those who bear a low to medium burden without the proposed mandates would continue to bear the same level of burden after the mandates. The proposed mandate on coverage of hearing aids for children between the ages of 13 and 18 has the potential to lower the health care financial burden for those families between 1% and 4%, although they would remain in the high burden category. For those who already bear a high financial burden related to health care, any additional cost can be a barrier to access.

Impact of mandate on use of procedure, service or equipment

The proposed mandates concerning ostomy supplies, wigs for alopecia areata, and cost sharing for second colonoscopies are not expected to significantly affect the use of the procedure, service or equipment concerned.

The costs of prosthetics and of hearing aids for teenagers have been major barriers to access for those without insurance coverage for these devices. The proposed mandates for coverage of these devices are not expected to increase the diagnosis of the conditions which require them, but demand for the devices is expected to increase among those who could benefit from them.

Insurance coverage for initial HLA testing could substantially increase the rate at which potential bone marrow donors enlist in the National Marrow Donor Registry, which will increase the demand for such testing.

The mandate on wellness programs with financial incentives is voluntary on the part of the employer. It is difficult to predict the impact of the mandate on employer selection of such programs, or on employee use of them. Financial incentives should increase participation, if such programs are in fact included by employers in their health plans.

Other states

Mandated coverage in other states for the proposed mandated benefits varies by benefit:

- Connecticut is the only state that mandates coverage of ostomy supplies in commercial health insurance policies.
- Five states mandate coverage for prosthetic limbs.
- Fifteen states mandate some level of coverage for hearing aids for children between ages 13-18.
- Four states mandate coverage for wigs for persons with alopecia areata. One applies a dollar limit and one limits the benefit to children under 18.
- Four states mandate coverage of initial HLA testing for purposes of enrolling in the National Marrow Donor Registry.
- 33 states mandate coverage for colonoscopies, although it could not be determined whether co-pays, deductibles and coinsurance for second or subsequent colonoscopies are eliminated in any of them.
- A number of states have studied wellness programs and several offer them to state employees. Few studies addressed the issue of financial incentives. No states were found to have mandated them.